Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: LES BENSON MD 1220 GUNNISON WACO, TX 76712	MFDR Tracking #: M4-10-2519-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: states in part, "…I provided a designated doctor examination of Donald Rankin on 3/23/09…I submitted a bill for this service 4/13/09…I did not receive an EOB or payment within forty –five days…I sent a request for reconsideration on 11/2/09…I did not receive an EOB or payment…"

Amount in Dispute: $850.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: states in part, "…The provider submitted proof that it submitted its medical bill by fax to 866-286-0052 on April 13, 2009 and November 2, 2009. The provider did not submit proof that the medical bill was sent by any other method other than by facsimile…The carrier asserts that it received for the first time the provider's medical bill when it received the provider's request for medical dispute resolution on January 22, 2010...The carrier attaches emails from Wayne Gill, a senior claims examiner for the carrier, stating that the carrier's fax number is 866-296-0052...In fact, the provider identified the correct fax number in box 19 of its medical bill, but as can be seen on the provider's fax confirmation sheet, it sent the medical bills to an incorrect fax number. Wayne Gil further states that the fax number used by the provider is not owned or operated by the carrier…Since the carrier received the medical bill for the first time on January 22, 2010 and since the provider has not proven that an exception under section 408.0272 of the Texas Labor Code applies, the provider did not timely submit its medical bill to the carrier…"

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
03/23/09	99456 NM 99456 W8 RE	N/A	$850.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits 09/04/2009:
   - 080-001- Review of this bill has resulted in an adjusted reimbursement for the entire bill of $0.00.
   - 910-109 & 29-The time limit for filing has expired.

- W1- Workers Compensation State Fee Schedule adjustment.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Tex. Admin. Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Tex. Admin. Code §133.20(b) states in pertinent part "Except as provided in Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that §408.0272 applies to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Tex. Admin. Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the documentation submitted finds two copies of a medical bill, one stamped "Request for Reconsideration", both with printed date of 04/13/09 and carrier's fax number 866-296-0056 in box 19, two fax transmittal forms dated 04/13/2009 and 11/2/2009 addressed to New Hampshire Insurance, fax number 866-286-0052, two fax confirmation logs confirming fax was sent ok to 866-286-0052 on 04/13/2009 and 11/2/2009, and an EOB dated 02/02/2010 which was provided by the carrier. Although the requestor provided evidence of their submission of a medical bill, the submission was sent to an incorrect fax number of 866-286-0052. No documentation was found to sufficiently support, pursuant to §102.4(h), that the requestor sent bills to the carriers' correct fax number of 866-296-0052 within 95 days from the date the services were provided.

2. In accordance with Tex. Lab. Code Ann. §408.027, the health care provider and requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the service in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.